Payment Error Rate Measurement (PERM) 2019

Frequently Asked Questions About the PERM Program

What is PERM?
The Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the heads of Federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments, to estimate the amount of improper payments, to report those estimates to the Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures.

The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and the State Children's Health Insurance Program (CHIP) and produces state and national-level error rates for each program. The error rates are based on reviews of Medicaid and CHIP fee-for-service (FFS) and managed care payments made in the Federal fiscal year (FY) under review.

What does PERM Program do?
The purpose of PERM is to examine claims payment in the Medicaid program and Children's Health Insurance Program (CHIP) for accuracy and to ensure that the States only pay for appropriate claims.

How often are states measured under PERM?
PERM uses a 17-state rotational approach to measure improper payments in Medicaid and CHIP for the 50 states and the District of Columbia over a three-year period. As a result, each state is measured once, and only once, every three years. The rotation allows states to plan for the reviews because they know in advance when they will be measured.
The 2019 PERM cycle will focus on Medicaid/CHIP claims paid during state fiscal year 2019 (July 2018 – June 2019). Both provider payments and beneficiary eligibility will be reviewed, after being put on hold the last 2016 PERM cycle due to the newness of the Affordable Care Act (ACA).

How do I know if PERM Review applies to me? Payments made to all provider types will be part of the review process. Any claim that is paid by Vermont Medicaid between July 1, 2018 and June 30, 2019 will be part of the payment universe review. A sample of claims will be randomly drawn from each quarter, and these will be the claims reviewed by the federal contractor. **If a claim you submitted is selected, you will be notified.**

Who will contact me if I am selected?

Vermont Medicaid will outreach to you if you are selected to validate who should be contacted to get appropriate Medical records. AdvanceMed, the medical review contractor for CMS, will then contact providers and request a copy of their medical records to support the medical review. AdvanceMed will send out the request letters and, if necessary, follow-up letters and calls. ***Please note you are required to submit records at no cost to AdvanceMed. You cannot bill for cost of copying or mailing records.***

What do I need to provide if I am selected? AdvanceMed will tell providers what to send, where to send it and when. The documentation may include medical information, proof of medical necessity, and proof that the services were provided as ordered and billed with correct codes.

To see what the request letters from AdvanceMed will look like, see (hyperlink to sample docs).

What medical documentation should I expect to submit if I'm selected in the 2019 PERM audit? Providers should visit (hyperlink to matrix) if they have questions about what documentation they are expected to submit if their claims are selected for the PERM audit.

Note: The list is sorted by provider Type of Service

What is the time frame to send in documentation? Providers have 30 days from the date of receipt of notice from AdvanceMed (not Vermont Medicaid) to submit required claims medical records and adjoining documents to AdvanceMed. Providers have 7 days from the date of receipt of notice, of request for additional information to submit additional claims documentation for inaccurate medical record and adjoining documents, to AdvanceMed.

What happens if I don't send in the documentation on time? Providers selected for the sample are required to submit all requested documentation to AdvanceMed as stated in your signed Provider Enrollment Agreement (Section 6) or, if you have recently revalidated your enrollment, your signed General Provider Agreement (Article VI, Section 1).

DVHA will enforce a 10% withholding of the remittance advice for providers that do not submit the required medical records and adjoining documents within 30 days or the additional documentation within 7 days. The withholding will continue until such time the issue is resolved.

Will you be recovering money from me if an error is found? If an overpayment is discovered, the provider must return the overpayment to the state within 60 days of identification of the overpayment. The state will pursue recovery of the improper payment from the provider. The state is required to return to CMS the federal share of any overpayment.

Who do I contact if I have further questions? Additional information is available at http://dvha.vermont.gov/for-providers/payment-error-rate-measurement-perm/view or you can call Provider Services Monday through Friday from 8:00am to 5:00pm, toll-free in Vermont (800) 925-1706; local and out-of-state (802) 878-7871.